

January 28, 2016

Health Policy Commission
Attn: Catherine Harrison
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Executive Director Seltz:

Boston Children's Hospital (BCH) and the Children's Hospital Integrated Care Organization (CHICO) would like to submit the following comments with respect to the Health Policy Commission's (HPC) proposed certification standards for accountable care organizations in Massachusetts. As you know, BCH is the largest provider of care to children in the Commonwealth, and especially serves a substantial number of low-income children and children with chronic and complex medical conditions. We have some significant experience and insight into accountable care development and alternative payment models in pediatrics through our work on the BCBS AQC (first pediatric-specific AQC contract), our efforts to develop a Medicaid ACO entity, and our leadership in the Children's Hospital Association's analytic and legislative proposal to establish Medicaid alternative payment models for higher complexity children.

Each of these initiatives has required us to undertake focused analytic, quality measurement and program implementation work that has provided significant insight into pediatric-specific opportunities and challenges. We remain convinced that the "devil is in the details" and that we are still in very early stages of our collective efforts to embrace a more accountable, patient-focused health system.

General Comments

1. The Health Policy Commission should not make certification so burdensome that few providers apply to be certified as an ACO. Based on the certification standards presented, we are deeply concerned that many will choose not to apply, and at a minimum, will carefully evaluate the proposed benefit (somewhat speculative Medicaid DSRIP funding) against the very real application and reporting burden. It has not been our experience to date that HPC application and reporting processes are straightforward. Analogous certification processes, like NCQA for medical homes are expensive and time-consuming, causing many providers to choose not to certify.
2. The Health Policy Commission should not mandate specific approaches if there is no strong evidence base to suggest the approach will be efficacious. While we agree that there are many interesting approaches that may seek to address the triple aim, these approaches are frequently speculative, based on limited experience or require further refinement. Our own Community Asthma Initiative is a good example. Our toolkit of interventions is relatively well-established



and well-studied for children that have experienced asthma-related admissions or emergency room care (focusing on more intensive patient education, utilizing home visits to address environmental triggers, supplying non-traditional durable medical equipment like HEPA vacuums). However, the application of these tools to an expanded and more heterogeneous population (those seen in primary care that have not yet had an admission/ED visit) is still a work in progress. Mandating this kind of approach is well-intentioned, but may or may not save money and improve quality.

3. As a related manner, the Health Policy Commission should not mandate approaches and interventions that have not been previously mandated for payors. If we are unable to convince the relevant legislators and regulators that a proposed benefit should be mandated for the fully insured, we should not mandate it for ACOs. For example, we have never been able to mandate the use of community health workers by private payors, nor telemedicine coverage, nor a requirement that they contract for geographically diverse community-based services (like MassHealth's CBHI services). Requiring ACOs to provide these services through a certification process without similarly mandating that payors provide them seems at best disproportionate to the relative size and capabilities of major, established, data-rich payors versus potentially much smaller, information ACOs .
4. The Health Policy Commission should not make ACO certification "exclusive." There are multiple approaches to alternative payment models such as participation in the Blue Cross Blue Shield AQC, or many of the Medicare opportunities. These may prove to be superior to certification as an ACO in terms of the cost-benefit impact and cost and quality outcomes and should not be precluded by these regulations. The delivery system is very much evolving and the HPC should seek to encourage, rather than discourage, innovation and diverse approaches.
5. The Health Policy Commission should recognize that focal areas, capabilities, and interventions need to be specific to the patient population served by the ACO. For example, the measures, collaborations and potentially even the outcomes relevant to children may be very different than for adults.
6. The Health Policy Commission should not mandate things that are effectively unenforceable, or only enforceable using vague standards. Appreciating the HPCs desire to be comprehensive, there are many items in the draft standards that seem quite unenforceable absent the development of an enormous and costly bureaucracy. It is also not clear from the regulations what the HPC would do if ACOs were found out of compliance with the standards proposed. It does not seem to us that there are similar enforced standards imposed, for example, on the payor community (see point #3 above).
7. The Health Policy Commission should not use the certification process as yet another means of collecting data, asking a lot of questions, and educating itself on "what's working" as outlined in the preamble to the standards. Certification (as distinct from other efforts) should be used to assure the public is protected, and that we advance the three part aim in an evolving health care



system, not to understand market trends or engage in academic analyses. As a related matter, all ACOs will have concerns about proprietary business information and trade secrets in supplying much of this information. HPC indicates ACOs may be required to submit nonpublic, clinical, financial, strategic or operational documents and information. Among other things, the ACO would be required to submit ACO participation agreements with providers, including compensation methodologies, ACO operational plans for assessing EMR adoption by provider type, specific conditions and methodologies for assessing variation among ACO providers, and a number of ACO training materials. The HPC states it will not disclose such information and documents without the consent of the ACO, except in summary form in evaluative reports, unless the HPC believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anticompetitive considerations. A “public interest” exception could result in disclosure of confidential or proprietary ACO information. Finally, the collection and aggregation of data and information becomes ever more complicated when the HPC seeks to impose its own views on how data should be structured and submitted (as evidenced by the work that has gone into the Registration of Provider Organization effort). We would strongly encourage the HPC to recognize that individual ACOs will have different, not mutually compatible, data collection and reporting systems, and that the HPC's role is to assure appropriate reporting, not to micromanage the process (as an analogous example, different payors use different approaches to report performance on HEDIS measures). We also believe HPC needs to provide much stronger protections around the data ACOs are required to provide and should not be permitted to disclose such information if in its sole discretion the HPC deems it to be in the public interest.

8. The Health Policy Commission should clarify whether it is providing a safe harbor or otherwise waiving application of the state's anti-kickback, false billing and physician self-referral laws for financial arrangements and other activities necessary for and related to the ACO's certification and operations, such as distributions of shared savings among ACO participants, providers or suppliers. Similarly, the clinical and operational integration required for ACOs to function optimally needs to be analyzed under applicable antitrust regulation and the HPC will need to determine ways to accommodate ACO structures that may otherwise violate those regulations though consistent with the intent of achieving shared savings and improving patient care. The federal government has promulgated such participation waivers for the Medicare Shared Savings Program and HPC should do the same.
9. Given the complexity of the draft standards, the Health Policy Commission should offer specific, detailed, written responses to comments received (similar to the federal rule-making process) before putting out a final draft.

Specific Comments

1. The certification standards in a number of places propose effectiveness measures for the ACO which may frequently be redundant to those imposed on primary care medical homes. As we have stated many times, we do not believe that ACO certification should require PCMH



certification. An integrated system attempting to deliver patient centered care may choose to provide some functions centrally that would otherwise be required via PCMH certification. ACOs should be tasked with delivering outcomes, not with using specific approaches to achieve them. The literature on how to measure ACO effectiveness is not yet mature (see General Comment #2) and the work required to report effectiveness in a non-cursory way is quite substantial. As a corollary point, the costs of a three year cycle of NCQA recognition would be more than \$400,000 every three years in fees alone. The labor costs would be at least as large if included, and the effort would run the risk of diverting attention from equally or more important population health initiatives (in our case the deployment of a system-wide primary care EMR platform). Consequently, the cost-benefit analysis of this approach must be very carefully evaluated for the reasons cited above.

2. Payors are already subject to Office of Patient Protection oversight, and will be the entities making the determination of whether specific services are medically necessary, etc. To the extent an ACO is acting as a payor, it should be subject to the same rules (including registration as an insurer and RBPO filings for example). It is not our understanding that most ACOs will be acting as payors in the short-term. That said, most health systems do have patient relations functions used to resolving patient complaints and providing direction; being asked to describe these functions within the organization would be appropriate.
3. Requirements to develop preferred provider networks for “external” functions as implied in several places (and often with a geographic basis) would be extremely difficult to achieve for a statewide organization with a dispersed patient population like BCH/CHICO (see for example criteria 9, 10 and 15). These requirements seem to assume that ACOs will be tightly geographically bounded. We know this is not true for pediatrics, and expect it may not be true in the adult world either. As an example, contracting with community-based organizations in any jurisdiction in which more than 100 members live might include most of the cities and towns in Massachusetts for Boston Children’s Hospital.
4. We strongly believe that ACOs will need to address behavioral health concerns within their systems; it is a fundamental component of our current PCMH and ACO implementation work. We just as strongly believe that the current behavioral health system is siloed, disorganized, provides limited payor accountability (see General Comment #3 above), suffers from inadequate networks and insufficient implementation of evidence-based practices, and is under resourced and underfinanced. As such, we strongly encourage the HPC to tread carefully before mandating specific approaches, network standards, or contracting requirements prior to addressing the many, many structural issues that underlie the current dysfunctional system.



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